Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXOMA MEDICAL CENTER
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
Texas Mutual Insurance Co.

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-2435-01

MFDR Date Received
March 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $3,728.42, minus their payment of $3,039.79 there is still an outstanding balance of $688.63. We have submitted an appeal to the carrier but they have chosen to deny our request for the additional allowance."

Amount in Dispute: $688.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor asserts it is due additional payment in the form of an outlier payment for hospital outpatient hospital serviced billed January 4, 2011. Texas Mutual is not convinced the assertion is valid."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2011	Outpatient Hospital Services	$688.63	$159.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 7, 2011

   - CAC – B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS
   - CAC – W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - CAC – 97 THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 356 – THIS ALLOWANCE WAS BSED ON THE PART B FEE SCHEDULE AMOUNT.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 790 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE AYMENT OF OTHER SERVIES PERFORMED ON THE SAME DATE OF SERVICE.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated March 7, 2011

   - CAC – B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS
   - CAC – W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - CAC – 193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIMWAS PROCESSED PROPERLY
   - CAC – 97 THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 356 – THIS ALLOWANCE WAS BSED ON THE PART B FEE SCHEDULE AMOUNT.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 90718, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J0330, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J1170, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2250, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2765, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J7030, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J7040, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 96376, date of service January 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415, date of service January 4, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80048, date of service January 4, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89. The recommended payment is $14.89.
   - Procedure code G0434, date of service January 4, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $15.64. 125% of this amount is $19.55. The recommended payment is $19.55.
   - Procedure code 86850, date of service January 4, 2011, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of $14.93. This amount multiplied by 60% yields an unadjusted labor-related amount of $8.96. This amount multiplied by the annual wage index for this facility

of 0.9561 yields an adjusted labor-related amount of $8.57. The non-labor related portion is 40% of the APC rate or $5.97. The sum of the labor and non-labor related amounts is $14.54. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $14.54. This amount multiplied by 200% yields a MAR of $29.08.

- Procedure code 86900, date of service January 4, 2011, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of $7.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $4.67. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $4.46. The non-labor related portion is 40% of the APC rate or $3.11. The sum of the labor and non-labor related amounts is $7.57. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $7.57. This amount multiplied by 200% yields a MAR of $15.14.
- Procedure code 86901, date of service January 4, 2011, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of $7.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $4.67. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $4.46. The non-labor related portion is 40% of the APC rate or $3.11. The sum of the labor and non-labor related amounts is $7.57. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $7.57. This amount multiplied by 200% yields a MAR of $15.14.
- Procedure code 85027, date of service January 4, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.11. 125% of this amount is $11.39. The recommended payment is $11.39.
- Procedure code 73130, date of service January 4, 2011, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $25.83. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $43.85. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $43.85. This amount multiplied by 200% yields a MAR of $87.70.
- Procedure code 26951, date of service January 4, 2011, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0053, which, per OPPS Addendum A, has a payment rate of $1,182.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $709.32. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $678.18. The non-labor related portion is 40% of the APC rate or $472.88. The sum of the labor and non-labor related amounts is $1,151.06. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $1,151.06. This amount multiplied by 200% yields a MAR of $2,302.12.
- Per Medicare policy, procedure code 90471, date of service January 4, 2011, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 90471, date of service January 4, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.81. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $15.12. The non-labor related portion is 40% of the APC rate or $10.54. The sum of the labor and non-labor related amounts is $25.66. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $25.66. This amount multiplied by 200% yields a MAR of $51.32.
- Per Medicare policy, procedure code 96374, date of service January 4, 2011, may not be reported with

procedure code billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96374, date of service January 4, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of $22.13. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $21.16. The non-labor related portion is 40% of the APC rate or $14.75. The sum of the labor and non-labor related amounts is $35.91. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $35.91. This amount multiplied by 200% yields a MAR of $71.82.

- Per Medicare policy, procedure code 96375, date of service January 4, 2011, may not be reported with procedure code billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96375, date of service January 4, 2011, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of $22.13. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $21.16. The non-labor related portion is 40% of the APC rate or $14.75. The sum of the labor and non-labor related amounts is $35.91 multiplied by 2 units is $71.82. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $71.82. This amount multiplied by 200% yields a MAR of $143.64.
- Per Medicare policy, procedure code 99284, date of service January 4, 2011, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 99284, date of service January 4, 2011, has a status indicator of Q3, which denotes codes that may be paid through a composite APC; payment is packaged into a single payment for specific combinations of service. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $133.55. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $127.69. The non-labor related portion is 40% of the APC rate or $89.03. The sum of the labor and non-labor related amounts is $216.72. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this line is $216.72. This amount multiplied by 200% yields a MAR of $433.44.

4. The total allowable reimbursement for the services in dispute is $3,198.98. This amount less the amount previously paid by the insurance carrier of $3,039.79 leaves an amount due to the requestor of $159.19. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $159.19.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $159.19 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 18, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.